DRG Payment Calculation Worksheet
Basic and Final Price
Admissions 07/01/95 and After

[1] DRG code (from the voucher): _____
If one of the following is true, **do not complete the form.** The claim is not subject to the DRG PPS reimbursement methodology.

=
- The category of service is not 20.
- The DRG code is 103, 436, 462, 480, or 481.

[2] Hospital base price (Table A, item 8) _____

[3] DRG relative weighting factor (from Table B) _____

[4]= Transfer-in adjustment factor _____
- For DRGs 370-375 and admission source 4, subtract 0.2012.
- For DRGs 385-391, 985-987 and 989 and admission source 4, add 0.2012.
- For admissions 01/01/06 and after, for DRGs 370-375 and admission source D, subtract 0.2012.
- For admissions 01/01/06 and after, for DRGs 385-391, 985-987 and 989 and admission source D, add 0.2012.
- In all other situations, use 0.0000.

[5] Adjusted weighting factor (line [3] + line [4]) _____

[6] DRG base price (line [2] x line [5]) _____

[7] Transfer out adjustment factor (from page 2, line [8]) _____
(1.000, unless patient was transferred to another short-term hospital)

[8] Transfer adjusted DRG price (line [6] x line [7]) _____

Outlier adjustment:

[9] Length of stay (from page 3, line [10]) _____

[10] Cost (from page 4, line [16]) _____

[11] Larger of the two outlier amounts (line [9] or line [10]) _____

[12] DRG price (line [8] + line [11]) _____

Add-ons (from Table A):

[13] Capital cost (from Table A, item 9) _____

[14]*=Disproportionate Share Rate x Covered Days= _____

[15]*=Medicaid Percentage Adjustment Rate x Covered Days= _____

[16]*=Medicaid High Volume Rate x Covered Days = _____
- For admissions 10/01/93 and after, use the per diem rate that is in effect on the date of admission

[17]= Total reimbursement (sum of line [12] through line [16]) _____
(This total does not include adjustments for co-payment, third-party liability , and other adjustments)

*These rates are identified in annual rate letters from the department.

Transfer-out Adjustment
Admissions 07/01/95 and After

[1]= Patient status code (from claim): _____

= If patient status at discharge is NOT coded 02, transfer to another short-term hospital, or (after 01/01/06) 66 - discharged/transferred to a Critical Access Hospital (CAH), then STOP. The claim is not to be adjusted for a transfer-out proration. Go to line [8] and enter one (1.0000).

[2]= Claim DRG _____

Computed adjustment factor:

[3]= Length-of-stay (covered days) _____

[4] Geometric mean length-of-stay (GLOS) (from Table B) _____

[5] Computed adjustment factor (line [3] divided by line [4]) _____

[6] Lesser of line [5] and 1.000 _____

[7] Transfer-out adjustment for exceptions _____
- For DRGs 385, 456, and 985, enter 1.0000
- In all other situations, enter 0.0000

[8] Transfer-out adjustment factor
(Greater of line [6] or line [7]) _____

Carry the final figure from line [8] over to Page 1 line [7].

Length-of-stay Outlier
Admissions 07/01/95 and After

[1] DRG code (from claim): _____
If the DRG code is within the range of 424-432, then **STOP**. The claim is not subject to reimbursement for length-of-stay outliers.

[2]= Length-of-stay (covered days) _____

[3] DRG outlier cut-off threshold (OCT) (from Table B) _____

[4] Outlier days (line [2] - line [3]) _____
If the result in [4] is less than or equal to zero, then **STOP**.
The claim is not subject to reimbursement for length-of-stay outliers. Go to line [10] and enter zero (0).

[5] DRG federal portion (from Table A, item 6) times
DRG weight (from Page 1, line 5) _____

[6] Geometric mean length-of-stay (GLOS) (from Table B) _____

[7] DRG base price per diem (line [5] divided by [6]) _____

[8] Marginal cost factor: 0.47

[9] Multiply (line [7] x line [8]) _____

[10] Day outlier payment (line [4] x line [9]) _____

Carry the final figure from line [10] over to Page 1 line [9] of the DRG Payment Calculation Worksheet.

Cost Outlier for DRG-Reimbursed Hospitals
Admissions 12/03/01 Through 06/30/05 And Admissions 07/01/05 and After

[1] DRG code (from paid claim): _____

[2]= Total charges _____

[3]= Noncovered charges _____

[4] Net charges (line [2] - line [3]) _____

[5] IME factor (from Table A, item 18) _____

[6] IME adjusted charges (line [4] divided by line [5]) _____

[7] Cost to charge ratio (from Table A, item 3) _____

[8] Net covered cost (line [6] x line [7]) _____

[9] Federal rate (from Table A, item 6) _____

[10] DRG relative weighting factor (from Page 1, line 5) _____

[11] National DRG rate (line [9] x line [10]) _____

[12] Specific fixed loss threshold (Table A, item 17) **x1.22**
admissions 12/03/01 through 06/30/05
OR _____
= Specific fixed loss threshold (Table A, item 17) **x 1.40**
for admissions 07/01/05 through 06/30/06
OR
= Specific fixed loss threshold (Table A, item 17) **x 1.47**
for admissions 07/01/06 and after

[13] Cost outlier threshold (line [11] plus line [12]) _____

[14] Gross outlier cost (line [8] - line [13]) _____
If the result in [14] is less than or equal to zero, then **STOP**.
The claim is not subject to reimbursement for cost outliers.
Go to line 16 and enter zero (0).

[15] Marginal cost factor (effective 1/1/95) 0.80

[16] Cost outlier adjustment (line [14] x line [15]) _____

Carry the final figure from line [16] over to Page 1 line [10] of the DRG Payment Calculation Worksheet.

Outlier Adjustment Calculation for
Per Diem Priced Claims

For a disproportionate share provider to qualify for an outlier, the patient must be under age six. For a non-disproportionate share provider, the patient must be under age one.

Provider information needed:
*****daily per diem rate
*****daily disproportionate share rate
*****daily MHVA rate
*daily MPA rate
outlier standard deviation amount (in effect on admission date)
outlier cost-to-charge ratio (in effect on admission date)

Claim information needed:
total covered charges
total covered days

*****If the date of service crosses a rate period where there is a rate change, you will have to do steps 5 through 11 twice (one calculation for each rate period) and then add them together.

[1] Outlier standard deviation $_____

[2] Total covered charges $_____

Compare total covered charges to the outlier standard deviation. If total covered charges are less than the outlier standard deviation, then **stop**. The claim is not eligible for outlier consideration. If total covered charges are greater than the standard deviation, proceed to step 3.

[3] Outlier cost-to-charge ratio _____

[4] Multiply line 2 times line 3 $_____

[5] Per diem rate $_____

[6] Disproportionate share rate $_____

[7] MHVA rate $_____

[8] MPA rate $_____

[9] Total of lines 5, 6, 7, and 8 $_____

[10] Number of covered days _____

[11] Multiply line 9 times line 10 $_____

[12] Line 4 total minus line 11 total $_____

[13] If step 12 total is zero or less, **stop**. The claim is not eligible for an outlier.
For admissions between December 3, 2001 and June 30, 2005:
If step 12 is greater than zero, then take step 12 total
X .22 (factor .22 is used for all hospitals) Outlier Amount Due $_____

= **For admissions between July 1, 2005 and June 30, 2006:**
If step 12 is greater than zero, then take step 12 total
X .20 (factor .20 is used for all hospitals) Outlier Amount Due $_____

= **For admissions on or after July 1, 2006:**
If step 12 is greater than zero, then take step 12 total
X .18 (factor .18 is used for all hospitals) Outlier Amount Due $_____

EXAMPLE

Provider information:		**Claim information:**	
***daily per diem rate**	$ 1,219.11	total covered charges	$152,564.09
***daily disproportionate share rate**	$ 60.60	total covered days	45
***daily MHVA rate**	$ 87.38		
*daily MPA rate	$ 52.40		
outlier standard deviation amount	$52,682.40		
outlier cost-to-charge ratio	.50		

[1]	Outlier standard deviation		$ 52,682.40
[2]	Total covered charges		$ 152,564.09

Compare total covered charges to the standard deviation. If total covered charges are less than the outlier standard deviation, then **stop**. The claim is not eligible for outlier consideration. If total covered charges are greater than the standard deviation, proceed to step 3.

[3]	Outlier cost-to-charge ratio		.50
[4]	Multiply line 2 times line 3		$ 76,282.05
[5]	Per diem rate	$ 1,219.11	
[6]	Disproportionate share rate	$ 60.60	
[7]	MHVA rate	$ 87.38	
[8]	MPA rate	$ 52.40	
[9]	Total of lines 5, 6, 7, and 8	$ 1,419.49	
[10]	Number of covered days	45	
[11]	Multiply line 9 times line 10		$ 63,877.05
[12]	Line 4 total minus line 11 total		$ 12,405.00

[13] If step 12 total is zero or less, **stop**. The claim is not eligible for an outlier.

For admissions between December 3, 2001 and June 30, 2005:
If step 12 is greater than zero, then take step 12 total
X .22 (factor .22 is used for all hospitals): Outlier Amount Due $ 2,729.10

= **For admissions between July 1, 2005 and June 30, 2006:**
If step 12 is greater than zero, then take step 12 total
X .20 (factor .20 is used for all hospitals) Outlier Amount Due $ 2,481.00

= **For admissions on or after July 1, 2006:**
If step 12 is greater than zero, then take step 12 total
X .18 (factor .18 is used for all hospitals) Outlier Amount Due $ 2,232.90